Clinical experience with an antimicrobial hydrogel dressing on recalcitrant wounds

- **Objective:** To assess the performance of a newly-introduced, iodine-based antimicrobial wound dressing (Iodozyme) within normal clinical practice.

- **Method:** 51 case records were collected from 30 wound care locations in England. Reporting clinicians used Iodozyme on one or more difficult wounds of their own choice (of various aetiologies) from their current case loads. Basic patient-specific data were collected, relating to both their own and their patients’ experience with the product over a 6-week period of treatment (or less, if healing was achieved earlier). In every case, the wound continued to be treated in accordance with local ‘best practice’, in accordance with the manufacturer’s instructions and by the same clinician. Each wound was assessed in terms of size, condition (margins and wound bed), exudate (type and amount), comfort/pain, overall satisfaction (by patient and clinician) and healing status (in terms of healed, improved, static or deteriorated). In addition, clinicians were asked to use their own local criteria and parameters where possible, with general guidance as and when it was needed.

- **Results:** The mean duration of all wounds was 25.8 months (median 13 and range 1–312). Nine patients had a wound of less than six months’ duration, and 17 had one of two years’ or more duration. Within the 6-week study period, 6 wounds healed fully, 37 were judged to have improved, 7 remained static and 1 deteriorated. Overall, the majority of clinicians and patients were ‘satisfied’ or ‘very satisfied’ with product performance and 77% of clinicians concluded that the dressing was ‘better’ or ‘much better’ than other dressings they had previously used on similar wounds.

- **Conclusion:** While we cannot generalise from this study, the encouraging clinical results and positive patient and clinician feedback lead us to believe that Iodozyme is a dressing worthy of consideration when treating chronic wounds. These encouraging preliminary findings are now to be followed up with a randomised control trial.

- **Declaration of interest:** All authors are either previous or current employees of Archimed.

Iodozyme (Archimed) is a new type of antimicrobial hydrogel dressing for use on infected superficial wounds. Its natural enzyme system creates iodine within the dressing. Because of its broad spectrum of biocidal activity, iodine has been used in wound care for nearly 200 years. Early products used relatively high concentrations of iodine, which caused pain and staining. Modern products tend to use lower concentrations and/or slow-release agents such as povidone-iodine and cadexomer iodine, which have overcome these problems. Modern hydrogel wound care products have proved to be effective, comfortable, easy to use and cost effective. Used appropriately, they control wound surface hydration by absorbing excess exudate or donating moisture. Hydrogels have also been shown to be effective debriding agents.

Iodozyme is designed to harness the biocidal activity of iodine in an advanced hydrogel format. The sustained antimicrobial effectiveness of Iodozyme, when compared with other dressings, has been demonstrated in vitro. The only clinical trial of Iodozyme is a previously unreported open, non-comparative one, undertaken for registration and to gather evidence on its safety and efficacy. This was a single-centre, non-randomised, prospective, open study involving 32 subjects with superficial wounds of varying aetiologies exhibiting clinical signs of elevated bioburden (such as heat, pain, inflammation and malodour). None of the patients received immunosuppressants or systemic antibiotics. Results (unpublished) were available for 30 patients, of whom three (10%) healed completely, 21 (70%) showed an improvement, three (10%) showed no improvement and three (10%) deteriorated.

To gain field experience of the dressing in a larger number of patients with a variety of hard-to-heal wounds, an open, non-comparative, case-series study was conducted. A case-series design was used because it offered the opportunity for rapid recruitment at a range of expert centres, as well as structured feedback from their experienced staff. It also gave direct insight into the effectiveness of the new dressing when applied by nurses in real-life settings.
Iodozyme (the test dressing) is a new type of wound dressing that uses a natural enzyme (glucose oxidase) to generate iodine. The enzyme does not act as a proteolytic aid to debridement or come into direct contact with the wound.

The dressing comprises two advanced polymer sheet hydrogels. One (secondary layer) contains a low level of glucose oxidase and the other (the primary layer) glucose and potassium iodide. When the dressing is placed over the wound, the diffusion of oxygen from the atmosphere into the secondary layer results in the production of hydrogen peroxide. This, in turn, is diffused into the primary layer, resulting in the production of molecular iodine. The peak level of iodine is approximately 0.2% w/w. This is about five times higher than that produced in its sister dressing, Oxyzyme, which is indicated for non-infected wounds.

**Method**

Patients were recruited from 30 centres in England (Box 1). These centres ranged from district nurse bases to complex wound care clinics. Recruitment was over a period of 12 months.

All patients had been receiving treatment for their wounds before being recruited into the study. Other than the use of the study dressing, each patient’s care regimen remained the same, both before and during the study. For example, patients continued to be treated in the same care setting and by the same clinician/carer, while the use of ‘gold standard’ treatments, such as compression bandaging, offloading and pressure redistribution remained unchanged.

Previous treatments had included the use of other advanced dressings.

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**Box 1. English clinicians/centres involved in the study**

Claire Acton, Queen Elizabeth Hospital, London
Rachel Baker, Podiatrist, Queen’s Hospital, Burton-on-Trent
Simon Barrett, Anlaby Clinic, Hull, Yorkshire
Alison Blacker, Salter’s Meadow Health Centre, Burntwood, Staffordshire
Eileen Booth, Beeches Medical Practice, Shrewsbury
Cathie Bree-Aslan, TVCS Ltd, Eastbourne, East Sussex
Jane Cadogan, Great Western Hospital, Swindon
Debbie Capewell, Langton Grange Medical Centre, Lichfield
Anne Coglan, Springfields Health Centre, Rugeley, Agnes Collate, St Charles Hospital, London
Mark Collier, Pilgrim Hospital, Lincolnshire
Keith Cutting, Health Directions Ltd, Hertfordshire
Jan Deane, Burntwood Health Centre, Staffordshire
Lindy Fairhurst, Royal Albert Edward Infirmary, Wigan
Fiona Fox, Manor Hospital, Walsall, West Midlands
Judy Gallimore, Silverdale Health Centre, Rugeley
Lorraine Grothier, St Peter’s Hospital, Essex
Sylvie Hampton, TVCS Ltd, Eastbourne, East Sussex
Susan Hayes, Good Hope Hospital, Birmingham
Dr Mark Hedges, Sharnbrook, Bedford
June Hogan, Kingshurst Clinic, Birmingham
Sue Huddart, New Cross Hospital, Wolverhampton
Gilly Josson, Leighton Hospital, Crewe, Cheshire
Tina Jarvest, Silverdale Health Centre, Rugeley
Teresa Mitchell, St George’s Hospital, Havering, Essex
Denise Moore, Ombersonly Health Centre
Phil Moss, Salter’s Meadow Health Centre, Burntwood
Sharon Robey, Smallwood Health Clinic, Redditch
Deborah Robinson, Bedford PCT
Jane Stevens, St George’s Hospital, Havering, Essex
Ian Tarr, Manor Hospital, Walsall,
Martin Turnes, South Downs PCT, Brighton
Margaret Wallace, Bedford PCT

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**Table 1. Baseline wound characteristics**

<table>
<thead>
<tr>
<th>Wound type</th>
<th>No. of wounds</th>
<th>Mean age (years) (median, range)</th>
<th>Mean wound duration (months) (median, range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial leg ulcer</td>
<td>11</td>
<td>76.4 (82, 43–90)</td>
<td>13.6 (12, 3–24)</td>
</tr>
<tr>
<td>Diabetic foot ulcer</td>
<td>11</td>
<td>74.0 (85, 45–85)</td>
<td>20.6 (18, 10–36)</td>
</tr>
<tr>
<td>Miscellaneous*</td>
<td>7</td>
<td>60.4 (68, 27–87)</td>
<td>20.0 (12, 3–60)</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>4</td>
<td>83.3 (84.5, 71–93)</td>
<td>14.0 (15, 2–24)</td>
</tr>
<tr>
<td>Surgical wound</td>
<td>8</td>
<td>59.8 (62, 34–81)</td>
<td>5.4 (6, 1–13)</td>
</tr>
<tr>
<td>Venous leg ulcer</td>
<td>10</td>
<td>66.2 (68, 43–81)</td>
<td>70.2 (30, 2–312)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>69.6 (75, 27–93)</strong></td>
<td><strong>25.8 (13, 1–312)</strong></td>
</tr>
</tbody>
</table>

* Burns, insect bites etc.
Inclusion criteria
- Aged over 18 years
- Hard-to-heal (static or had deteriorated during the previous four weeks) wound that was suitable for treatment with one or more 10 x 10cm antimicrobial test dressing.

Exclusion criteria
- Known or suspected sensitivity or allergy to iodide or iodine
- Thyroid disorder, such as Hashimoto’s thyroiditis or non-toxic nodular goitre
- Pregnancy or breast-feeding
- Continuing medication with lithium.

Recruitment
Consecutive patients who met the inclusion criteria were recruited into the study by the investigating clinicians. All patients provided written informed consent for treatment. As the test dressing was used in accordance with its approved indications and not in a comparative trial, ethics committee approval was not required.

Procedures and assessments
The wound was cleansed in accordance with local practice and the test dressing was applied directly to the wound in accordance with the manufacturer’s instructions. Dressing change frequency was based on wound status and local practice (typically two to three changes per week).

The dressing was used for the duration of the six-week study period, unless full healing occurred sooner. Six weeks was considered sufficient time to show an effect; if there were no signs of improvement by this point, then the dressing was discontinued.

The following parameters were assessed at the patients’ entry into the study and at their weekly clinic visits:
- Size — the wound (plus paper ruler) was photographed at entry (before the test dressing was first applied), at weekly clinic visits, at the end of the study (or on early discontinuation) and at a subsequent four-week follow-up. Wound area measurements were derived from digital photographs taken by a single, trained operator (to minimise inter-operator variability), using proprietary software (Leg Ulcer TeleMedicine; see www.lutm.com).
- Exudate type and amount, as visually assessed by the treating clinician, who selected one of two predefined definitions as appropriate to the wound: distinct or indistinct (according to local best practice for assessment of wound condition)
- Condition of the wound margins, as visually assessed by the treating clinician, who selected one of two predefined definitions as appropriate to the wound: distinct or indistinct (according to local best practice for assessment of wound condition)
- Condition of wound bed and peri-wound skin, as visually assessed by the treating clinician. The clinician, using their own clinical judgment, selected the most appropriate predefined definition for the wound bed condition from the following list: black, necrotic, sloughy, healthy red granulation and pink epithelialisation. A relative percentage was attributed to the wound bed definition. The peri-wound margins were described as healthy, inflamed or macerated and again, the clinician was required to choose the most appropriate definition for the wound (according to local best practice for the assessment of wound condition)
- Continued measurement with lithium.

At the end of the study, the treating clinicians assessed overall clinical outcomes. These were defined as:
- Healed — the wound had fully re-epithelialised
- Improved — the wound area had reduced in size, or there was an overall improvement in the condition of the wound bed, based on visual assessment
- Static — no significant change in wound size or condition of the wound bed
- Deteriorated — the wound had increased in size (not as a result of debridement), or there was a general deterioration in the condition of the wound bed.

Finally, at the end of the study the patients’ and the clinicians’ overall assessments of the product were recorded. These overall assessments were the primary clinical outcome measures. The secondary measure was the clinicians’ overall rating of lodozyme, compared with other treatments used for similar wound types.

References
Results
Forty-five patients with 51 wounds (43 patients had single wounds, one patient had two arterial wounds and one had six diabetic foot ulcers) were recruited into the study from 30 centres in England. The recruitment of patients at study centres was mixed; some centres recruited several patients, while others recruited only single patients. Twenty-one were male and 24 female. The mean ages of the patients are given in Table 1, along with data on wound type and duration.

Wound types included arterial ulcers, diabetic foot ulcers, pressure ulcers, surgical wounds, venous leg ulcers and ‘miscellaneous wounds’, including burns, insect bites, necrobiosis lipoideca (an ulcer usually occurring in patients with diabetes) and vasculitic ulcers. Arterial ulcers (11/51 wounds) and diabetic foot ulcers (11/51 wounds) were the largest cohorts.

The mean duration of all wounds was 25.8 months (median 13 and range 1–312). Nine patients had a wound of less than six months’ duration, and 17 had one of two years or more.

Treatment of 12 wounds was discontinued before the end of the six-week study period. These were:

- 2/11 (18%) arterial leg ulcers
- 1/11 (9%) diabetic foot ulcers
- 2/7 (29%) miscellaneous wounds
- 2/4 (50%) pressure ulcers
- 2/8 (25%) surgical wounds
- 3/10 (30%) venous leg ulcers.

Reasons for discontinuation were: dressing slippage (n=1), bleeding (n=1), pain (n=2), deterioration (enlargement, maceration or inflammation) (n=4), hospitalisation (n=2), and clinician decision to change to an alternative dressing following elimination of infection (n=2). Details are given in Table 2.

Healing outcomes
Of the 51 wounds, six healed, 37 improved, seven remained static and one deteriorated. A breakdown of results for the various wound types is given in Table 3.

The mean percentage reduction in ulcer area after six weeks for all wound types was 19.8%, with the mean baseline area of 13.1cm² reducing to 10.5cm². The biggest percentage reduction (45.7%) was reported for surgical wounds. Full details are given in Table 4.

Pain/comfort scores
Some of the patients (22) did not express an opinion as to the comfort of the dressing, while 21 described it as comfortable or very comfortable. The remainder (8) reported pain during treatment with lodozyme.

The average reported pain score for ongoing pain on entering the study was 3.7 (mild to moderate), with one third of wounds reported as scoring >5 on the pain scale. By the end of the six-week study peri-

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Table 2. Description of patient withdrawals.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(bleeding)</td>
</tr>
<tr>
<td></td>
<td>81-year-old cancer patient with large venous leg ulcer (98cm²) of 4 years’ duration. Withdrawn after 1 week due to bleeding. There was no change in the wound area but in the opinion of the treating clinician, the condition of the wound bed had improved and signs of local infection had disappeared</td>
</tr>
<tr>
<td>2</td>
<td>(hospitalisation)</td>
</tr>
<tr>
<td></td>
<td>87 year old with recurring gout wound (0.25cm²) of 5 months’ duration on her great toe. Withdrawn after 1 week due to hospitalisation following a cerebral vascular accident. There was no change in wound area, but in the opinion of the treating clinician, the condition of the wound bed had improved and signs of local infection had disappeared</td>
</tr>
<tr>
<td>3</td>
<td>(slippage and faecal contamination)</td>
</tr>
<tr>
<td></td>
<td>93-year-old patient with ischaemic heart and peripheral vascular disease and a sacral pressure ulcer (category IV, 8cm²) of 18 months’ duration. Withdrawn after 1 week due to difficulty keeping dressing in place and faecal contamination. There was no change in wound area, but in the opinion of the treating clinician, the condition of the wound bed had improved and signs of local infection had disappeared</td>
</tr>
<tr>
<td>4</td>
<td>(pain)</td>
</tr>
<tr>
<td></td>
<td>79 year old with arterial leg ulcer (2cm²) of 3 months’ duration. Withdrawn after 4 weeks because of elevated pain (pain score increased from baseline of 6 to 7). No significant change in wound area or condition</td>
</tr>
<tr>
<td>5</td>
<td>(pain)</td>
</tr>
<tr>
<td></td>
<td>73 year old with non-healing surgical wound (2.3cm²) on nail bed of 13 months’ duration on her great toe. Withdrawn after 3 weeks due to non-dressing-related hospitalisation. The area of the wound had reduced to 1.4cm²</td>
</tr>
<tr>
<td>6</td>
<td>(deterioration)</td>
</tr>
<tr>
<td></td>
<td>45 year old with diabetic foot ulcer (0.4cm²) of 12 months’ duration on her heel. Withdrawn after 3 weeks due to increase in wound area (2cm²) and systemic infection (flu-like symptoms requiring systemic antibiotics)</td>
</tr>
<tr>
<td>7</td>
<td>(hospitalisation)</td>
</tr>
<tr>
<td></td>
<td>81 year old with venous leg ulcer (3cm²) of 2 years’ duration on his foot. Withdrawn after 5 weeks when the wound had become static after a ‘quite dramatic’ initial improvement. The patient noted discomfort. The clinician noted excellent debridement and reduction in inflammation and malodour, and felt that lodozyme had helped save the patient’s foot from amputation</td>
</tr>
<tr>
<td>8</td>
<td>(clinician decision following positive effect)</td>
</tr>
<tr>
<td></td>
<td>81 year old with pressure ulcer (3cm²) of 12 months’ duration on his foot (due to collapse of arch). Withdrawn after 5 weeks when the wound had become static after a ‘quite dramatic’ initial improvement. The patient noted discomfort. The clinician noted excellent debridement and reduction in inflammation and malodour, and felt that lodozyme had helped save the patient’s foot from amputation.</td>
</tr>
<tr>
<td>9</td>
<td>(clinician decision following positive effect)</td>
</tr>
<tr>
<td></td>
<td>81 year old with an infected insect bite wound (4cm²) of 2 years’ duration on her heel. Withdrawn after 1 week due to maceration, which caused difficulty walking, although there had been some improvement to the condition of the wound bed</td>
</tr>
</tbody>
</table>

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The average reported pain score had dropped to 2.6 (discounting all healed wounds). Two patients were withdrawn because of pain, but both were experiencing moderate/severe pain before inclusion.

Clinicians’ overall assessment
Of the 51 clinician assessments, four (8%) indicated that the test dressing was ‘much better’, 35 (69%) that it was ‘better’, nine (18%) that it was ‘similar’, three (6%) ‘worse’ and 0 (0%) ‘much worse’ than other dressings that they had used on similar types of wound.

Patient satisfaction
The majority of patients (73%, 37/51) reported that they were ‘satisfied’ or ‘very satisfied’ with the test dressing.

Discussion
While the sample size of this study was smaller than that in the similar study of Oxyzyme (n=100),7 the number was judged sufficient to give an indication of the efficacy and performance of the test dressing in real-life clinical settings. The patient demographics reflected the general incidence of hard-to-heal, chronic wounds in the population, with the expected high proportion of elderly patients. The relative proportions of different wound aetiologies (the largest cohorts being arterial ulcers, diabetic foot ulcers and venous leg ulcers, representing 63% [32/51] of wounds studied) is also in line with the incidence of wounds in the general population. Due to the open, non-comparative study design, statistical analysis was not undertaken.

There was considerable variation in healing outcome when comparing different wound aetiologies, with 30% (3/10) of venous leg ulcers healing fully. In the absence of rigorous statistical assessment, it is not possible to draw any firm conclusions but these results show that, in this small case series, the test dressing produced very good outcomes in this group. This is supported by the users’ conclusions.

Clinicians reported that 84% of the wounds either healed or improved. In the absence of a control, it is impossible to make any firm conclusions about how the test dressing compares with alternative dressings, other than to note that 77% of the clinicians considered the test dressing ‘better’ or ‘much better’ than other dressings previously used on similar wounds.

The overall number of patients withdrawn from the study (n=12) was not unexpected, given the patient population and the complex and difficult nature of the wound types included.

The overall proportion of positive outcomes was slightly higher than that observed in the larger, non-antimicrobial Oxyzyme case-series study,7 which had the same study design and assessment approach as this study.

Table 2. Description of patient withdrawals.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Reason for withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Increase in wound area (varicose ulcer)</td>
</tr>
<tr>
<td>12</td>
<td>Inflammation and itchiness (orthopaedic surgical wound)</td>
</tr>
</tbody>
</table>

Table 3. Wound status after 6 weeks

<table>
<thead>
<tr>
<th>Wound type</th>
<th>Healed</th>
<th>Improved</th>
<th>Static</th>
<th>Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial leg ulcer (n=11)</td>
<td>0 (0)</td>
<td>9 (82)</td>
<td>2 (18)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Diabetic foot ulcer (n=11)</td>
<td>0 (0)</td>
<td>9 (82)</td>
<td>1 (9)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Miscellaneous (n=7)</td>
<td>1 (14)</td>
<td>5 (72)</td>
<td>1 (14)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Pressure ulcer (n=4)</td>
<td>0 (0)</td>
<td>3 (75)</td>
<td>1 (25)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Surgical (n=8)</td>
<td>2 (25)</td>
<td>5 (63)</td>
<td>1 (12)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Venous leg ulcer (n=10)</td>
<td>3 (30)</td>
<td>6 (60)</td>
<td>1 (10)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total (n=51)</td>
<td>6 (11.8%)</td>
<td>37 (72.5%)</td>
<td>7 (13.7%)</td>
<td>1 (2.0%)</td>
</tr>
</tbody>
</table>

*Outcomes were recorded at six weeks, or earlier if the ulcer healed sooner or the patient was withdrawn from the study.

Table 4. Mean baseline and endpoint wound areas, and mean percentage reduction in wound area

<table>
<thead>
<tr>
<th>Wound type reduction</th>
<th>Mean baseline area (cm²) (median, range)</th>
<th>Mean endpoint area (cm²) (median, range)</th>
<th>Mean % area reduction over 6 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial leg ulcer</td>
<td>14.8 (11.2, 3.3–36.6)</td>
<td>11.6 (9.2, 1.0–30.0)</td>
<td>21.7%</td>
</tr>
<tr>
<td>Diabetic foot ulcer</td>
<td>6.1 (5.0, 0.4–28.0)</td>
<td>4.7 (2.3, 0.5–20.0)</td>
<td>23.3%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>8.9 (7.5, 0.2–27.3)</td>
<td>5.9 (3.9, 0.0–21.1)</td>
<td>33.5%</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>5.0 (4.5, 3.0–8.0)</td>
<td>4.4 (3.5, 2.4–8.0)</td>
<td>12.6%</td>
</tr>
<tr>
<td>Surgical wound</td>
<td>13.0 (6.0, 2.3–50.0)</td>
<td>7.1 (3.5, 0.0–29.8)</td>
<td>45.6%</td>
</tr>
<tr>
<td>Venous leg ulcer</td>
<td>25.0 (10.4, 2.1–98.0)</td>
<td>24.0 (7.6, 0.0–98.0)</td>
<td>4.1%</td>
</tr>
<tr>
<td>Total</td>
<td>13.1 (6.0, 0.23–98.0)</td>
<td>10.5 (4.0, 0.0–98.0)</td>
<td>19.8%</td>
</tr>
</tbody>
</table>
procedures as this study, but which used a larger (and international) patient group (n=100). In the Oxyzyme study, 73% of wounds were assessed as healed or improved (10% and 63% respectively) after six weeks of treatment, whereas in the present study 85% healed or improved (12% and 73% respectively). The number of wounds assessed as having deteriorated was also smaller in the present study (11% with Oxyzyme and 2% with Iodozyme).

The results of this study were generally similar to those of the unpublished Iodozyme clinical trial, referred to above.

It was not expected that this Iodozyme case-series would produce more favourable results than the Oxyzyme study. It was thought that the wounds selected for treatment with Iodozyme (an antimicrobial dressing) would be more difficult to resolve than the uninfected (but static) wounds recruited for the Oxyzyme study. These results may indicate that the elevated level of iodine in Iodozyme has an additional positive effect on wound status, afforded by its antimicrobial action. This is consistent with several published reports in which iodine (depending on dose) is considered to have actions beyond its antimicrobial effects, relating in part to the modulation of inflammatory processes.8,9

Study limitations relate to the small sample size and lack of a control. Furthermore, the methods used for assessing wound bed condition and exudate levels were not standardised and so are subjective, with a risk of inter- and intra-rater variability.

Further studies are planned and some have already been undertaken, including a caseload reduction audit at a leg ulcer clinic (in press).

**Conclusion**

With our clinical partners we assessed the progress of 51 superficial wounds of various aetiologies using the Iodozyme wound dressing for up to six weeks. The results were encouraging. Over three quarters (85%) reported healing or clinical improvement within this time period. Twelve per cent healed fully and a further 73% exhibited clinical improvement in the wound. Most patients and clinicians were ‘satisfied’ or ‘very satisfied’ with the product.

The results were superior to those obtained for Oxyzyme. It may be that the elevated iodine concentration in Iodozyme not only has an antimicrobial effect, but also reduces inflammation.

While we cannot generalise from this study, the encouraging clinical results and positive patient and clinician feedback lead us to believe that Iodozyme is a dressing worthy of consideration when treating chronic wounds.